Primary Healthcare

Which Clinical Diagnostic Tools are most Effective for the assessment of Women with the Menopause whilst Opioid Dependent?

--Manuscript Draft--

Manuscript Number:	PHC1050
Article Type:	CPD
Full Title:	Which Clinical Diagnostic Tools are most Effective for the assessment of Women with the Menopause whilst Opioid Dependent?
Short Title:	Menopause & Opioid Tools
Abstract:	Abstract Opioid addiction and the Menopause have intrinsic signs and symptoms, often complicated by a misdiagnosis affecting the treatment options, which could otherwise prolong life. The Menopause is commonly diagnosed in middle aged women by General Practitioners though blood and urinalysis. Opioid dependence is diagnosed through urinalysis, assessment and use of diagnostic tools. An understanding of utilising Clinical assessment tools can help reduce a misdiagnosis. Such interventions in clinical assessment should encourage health professionals to have the confidence in effective decision making.
Keywords:	Menopause, Opioid dependence, Hormone Replacement Therapy, Clinical Diagnostic tools
Manuscript Region of Origin:	United Kingdom

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Abstract

Opioid addiction and the Menopause have intrinsic signs and symptoms, often complicated by a misdiagnosis affecting the treatment options, which could otherwise prolong life. The Menopause is commonly diagnosed in middle aged women through blood testing and urinalysis. Equally, Opioid dependence is diagnosed through urinalysis, assessment and the use of diagnostic tools. An understanding of utilising Clinical assessment tools can help reduce a misdiagnosis and such interventions should encourage health professionals to have the confidence in effective decision making in clinical assessment.

Keywords: Menopause, Opioid dependence, Hormone Replacement Therapy, Clinical Diagnostic tools

Aims and Learning Outcomes

The Aim of this article is to help develop nurse's knowledge and understanding on which clinical diagnostic tools are most effective in diagnosing women who are opioid dependent and experiencing the Menopause. It will help to develop nurse's knowledge of Opioid dependence disorders, the inevitable effects of the menopause and how using clinical diagnostic tools can help reduce the detrimental effects of unwanted symptomatology. This article should enable health professionals to:

- Identify appropriate clinical diagnostic tools for diagnosing the Menopause and Opioid Dependence.
- Discuss factors that cause the onset of the Menopause in women and symptoms of Opioid Dependence that may interfere with a formal diagnosis.

- State how Opioid dependence and the Menopause can be assessed, detected and diagnosed effectively (to help distinguish these conditions).
- Explain the principals of managing Menopause occurrence, Opioid dependence and symptomatology.
- Discuss the implications of misdiagnosing the Menopause and Opioid dependence.

Introduction

Opioid Dependence is a chronic relapsing disorder associated with misuse and low mortality rates worldwide (Hser et al, 2013). Opioid dependence resulted in 51,000 deaths in 2013, up from 18,000 deaths in 1990 (Global Burden of Disease Study, 2015).The descriptive characteristics of opioid dependence includes a strong desire to take opiates, difficulties in controlling the use of opiates and a physiological withdrawal state (Praveen et al, 2012). There is a concern that women are being misdiagnosed with opiate withdrawal symptoms whilst displaying menopausal symptoms. Equally, women being diagnosed with the Menopause whilst displaying Opiate withdrawal symptomatology (Clayton & Ninan, 2010). The conflicting diagnoses could be due to identified similarities in the symptomatology (Table 1). This could result in treatment options being inaccessible, which could otherwise prolong the quality of life for both conditions (Fehring et al, 2006). The implications for Opioid dependent women being misdiagnosed could result in severe Opiate withdrawals, seizures, physiological and mental health distress. Opiate withdrawal treatment consists of hospital inpatient, community and GP pharmacological treatment (NICE, 2015).

Generally, the Menopause is an inevitable event affecting all middle-aged women and menopausal symptoms can differ in terms of severity and duration (Whitham, 2013). NICE guidance (2015) suggests that the women are more at risk of chronic disease after the Menopause. Chronic diseases may include osteoporosis, urogenital atrophy, cardiovascular disease and the risk of a stroke increases after the Menopause (British Menopause Society Council, 2011). Therefore, there is a need to accurately identify symptoms early, offer appropriate treatment and promote long-term health for women (Holloway, 2011). Diagnosing the Menopause is routinely assessed through blood and urine test results, self-diagnosis and determining the final menstrual cycle, which is normally 12 consecutive

months following amenorrhea (Brockie, 2013). However, the measurement of efficacy in diagnosing the Menopause is limited. Clinical Diagnostic Tools could potentially minimise the risk of a possible misdiagnosis, identify chronic health risks presented and guide the primary care nurse to make a reliable, valid and coherent assessment (Whitham, 2013).

Timeout 1: Medication: Opiate withdrawal symptoms can be severe and menopausal symptoms equally. What other Adjunctive therapies are appropriate for managing these symptoms? Check Drug Misuse and Dependence (NICE, 2007) & BNF 68 (2014): Oestrogens; female sex hormones for HRT.

The Opiate Dependence Symptomatology

Diagnosing Opioid dependence is established through urinalysis (Opiate metabolites in urine), history taking and examination (Praveen et al, 2012).Opioids are typically prescribed for people who have acute and chronic pain, cancerous and non- cancerous pain and Opioid addiction. Typically heroin, opium and or over the counter opioid medication is often misused (NICE, 2007).

Some of the Symptoms of withdrawal from Opioids are similar to the onset of the Menopause such as the early symptoms, psychological and other symptomatology. Table 1 is adapted by Holloway (2011) & (Kheirabadi et al, 2008) .

Table 1: Opiate withdrawal Symptoms V's Menopausal Symptoms

Opiate Withdrawal Symptoms	Menopausal Symptoms
Early symptoms Sweating Night sweats Increased tearing Insomnia Sleep Disturbances Shivering Increased Pulse Runny nose Yawning Skin-Crawling heart pounding; palpitations Muscle aches and pains **Psychological Symptoms** Agitation Anxiety Mood Changes irritability Dysphoria. **Late symptoms** Abdominal cramping Diarrhoea Dilated pupils Goose bumps Nausea Vomiting. (Kheirabadi et al, 2008)	**Vasomotor Symptoms** Sweating Night Sweats Hot Flushes Insomnia Sleep Disturbances Shivering Increased Pulse Nausea Palpitations **Vaginal and Urinary Symptoms** Vaginal Infections Post-coital Bleeding Dysuria **Psychological Symptoms** Anxiety Mood Changes Irritability Decreased Libido **Other Symptoms** Skin Crawling Amenorrhoea Abdominal Cramps Aches and pains in muscles; joints. (Holloway, 2011)

Arguably, Amenorrhea in women with Opioid dependence is a common condition. Opioid dependence symptomatology (Table 1) can also lead to a misdiagnosis of the early onset of the Menopause due to the presence of amenorrhoea (Reddy et al, 2010). Pharmacological treatment is a primary intervention for Opioid dependence (Table 2). Sometimes Opiate withdrawal requires medications which are controlled under the Drug Misuse Act (1971) such as methadone and buprenorphine (Hser et al, 2013). Methadone is usually given as a "first line choice" due to its cost effectiveness, alternative dosing and reduction in injecting behaviour and buprenorphine can equally be prescribed. However, buprenorphine has partial

agonistic properties which make precipitated Opiate withdrawal more prevalent in “first time prescribing” (NICE, 2015).

Interventions for Opioid Addiction

Induction onto Opioid Substitute Prescribing (OST) takes 2-4 weeks, with the risks of overdose and toxicity being prevalent (Mckeganey et al, 2013). Buprenorphine is effective in treating withdrawal from opiates, and it can shorten the length of detoxification. Buprenorphine can also be used for long-term maintenance, like Methadone (Praveen, 2012). Methadone is limited by side effects influencing compliance, resulting in inadequate treatment retention (Hser et al, 2013). Methadone induction involves slowly decreasing the dosage of over time, which helps reduce the intensity of opiate withdrawal symptoms (Beck et al, 2014). Other medications may be considered, such as anti-psychotics, anti-depressants and benzodiazepines for the management of an opioid detoxification (NICE, 2007). Table 2 demonstrates an outline of the management process associated with Opioid dependence and the Menopause in the UK.

Table 2: Principals in managing Opioid addiction and the Menopause in the UK (NICE, 2015)

Interventions	Opioid Treatment	Menopausal Treatment
Pharmacological	Methadone Buprenorphine Suboxone Benzodiazepine Lofexidine Paracetamol Hypnotic Anti- depressant medication Anti- Psychotic Anti Convulsant medication (BNF, 2014)	Hormone Replacement Therapy (HRT) Tibolone Ethinylestradol Raloxifene Dydrogesterone Medroxyprogesterone acetate Norethisterone Progesterone Uliprisal acetate Clonidine. Vaginal lubricants. Antidepressants (BNF, 2014)
Use of Pharmacological Treatment	Maintenance therapy for Opioid dependence Adjunctive therapy for opiate withdrawal &Psychiatric intervention. (Nice, 2015)	Relief of menopausal symptomatology e.g. hot flushes. Psychiatric intervention (NICE, 2015).
Psychosocial Interventions	Cognitive Behavioural Therapy (CBT) Contingency Management Relapse prevention. Motivational Interviewing Self- help Counselling Contingency Management (CM)(Perry et al, 2014)	Motivational Interviewing Cognitive Behavioural Therapy (CBT) Self- help Counselling (Perry et al, 2014)
Clinical Diagnostic Tools	COWS SOWS OOWS SDS	SWAN CV MVS MRS
Treatment Options	GP Counselling Primary/mental health care Needle exchange programmes Wound care clinics- ulcers/ pressure sores. Inpatient referrals for detoxification (Public Health England, 2014)	GP Counselling Primary/mental health care (British Menopause Society Council, 2011)

The nature of nursing Opioid Dependence requires a range of specialist therapies such as Psycho-social interventions (PSI). PSI secondary to pharmacological treatment supports people who are opioid dependent (Perry et al, 2014). Some interventions (Table 2) may include; Cognitive Behavioural Therapy (CBT) which is aimed at modifying cognitive processes and behaviour. Motivational Interviewing (MI) is a 'directive service user-centred' counselling therapy, developed to modify behaviour and 'Contingency Management' (CM) is a technique that provides a system of 'incentives' or 'reinforcement' to encourage abstinence (Klimas et al, 2014). PSI's support Opioid dependent women to develop coping mechanisms, daily living skills and techniques to control or abstain from drug use (Butler et al, 2014). CBT and 'Self-help' has also beneficial use for the stressful menopausal transition (Holloway, 2011).

BOX 1

Hormone Replacement Therapy (HRT) is an effective treatment for reducing the severity for vasomotor, psychological and urogenital symptoms (Brockie, 2013). The risks and benefits of HRT need to be discussed prior to treatment as the menopausal symptoms may return immediately on non-adherence to the medication. (Panay et al, 2013). There are a number of potential risks of breast cancer, deep vein thrombosis, stroke and coronary heart disease. The side effects of HRT medication are progestogen related: abdominal cramps, acne, anxiety, bleeding problems, depression, headaches and mood changes. (Holloway, 2011).

The Menopause Symptomatology

Menopausal symptoms naturally occur in women exhibiting the signs of peri-menopausal symptoms in their 40's, although this can occur in women in their early 30's and as late as their 50's (Whitham et al, 2013). The average age is not precisely defined, however, an important factor within the onset of the menopause. The Menopausal age is determined by genetics, environmental factors, surgery, chemotherapy and radiotherapy (Panay et al, 2013).

The Menopause is defined as the cessation of menstruation for a period of one year and follicles in the ovaries become less responsive to Follicle Stimulating Hormone (FSH) which stimulates the follicles prior to ovulation, until it ceases. FSH, estradiol and luteinizing hormone (LH) blood tests are routinely the most common way of diagnosing of the menopause (Holloway, 2011). International studies on effectively diagnosing the menopause suggest that blood testing for FSH and Estradiol is of limited value in establishing peri-menopause due to extreme monthly fluctuating levels (British Menopause Society Council, 2011). The confirmation of peri-menopause relies on a medical history taking and symptoms identification The Peri-menopause is the transitional phase from pre-menopause into Menopause. During the Peri-menopause 'vasomotor' or 'somatic' symptoms result from hormonal changes (Kahwati et al, 2005). Symptoms relating to the Menopause depend on lifestyle factors, hormones, health, relationships, genetic, and work (Table 1). Hormone Replacement Therapy (HRT) (Box 1) may be considered as an effective therapy in managing these unwanted symptoms. (Reddish, 2011).

TIME OUT 2:Examples on Establishing a correct Diagnosis

Table 1 introduces some of the signs and symptoms associated with the Menopause and Opiate withdrawal syndrome. Think about a middle aged woman you have nursed. Give an example on how the menopause could be incorrectly diagnosed in the context of your practice or expertise? What other health conditions resemble menopausal symptoms? What is the source of your information?

Diagnostic Tools for distinguishing the Menopause and Opioid Dependence

Unfortunately, no gold standard Clinical Diagnostic Tool exists for identifying women experiencing peri-menopausal symptoms. The evidence for utilising Clinical Assessment Tools for diagnosing the Menopause is limited in the U.K (Whitham et al, 2013). However, research is robust for the diagnosis and accurate assessment of Opiate withdrawal (Tompkins et al, 2009). Primary care nurses should effectively utilise an evidenced- based approach towards diagnosing health conditions. In addition, the use of Clinical Diagnostic Tools will improve health, prolong life and lessen the burden of unwanted symptoms (Fehring et al, 2006). Typically, General Practitioners (GP) diagnose early and late stages of the menopause. When the Menopause is detected, healthcare professionals rely on diagnosing the 'Menopause' through self-assessment, observations and having an awareness of the symptomatology presented (NICE, 2015). It is generally accepted that Pre, Peri and Post-menopause significantly impacts women's health (Panay et al, 2013).

TIMEOUT 3: Differential Diagnosis

Go online or use a standard textbook to check your knowledge on Differential diagnoses associated with the Menopause and Opiate withdrawal. What other conditions may be causing the symptoms? How can you ensure you determine a correct diagnosis?

Risk assessment plays an important role in the diagnosis and the identification of the Menopause (Reddish, 2011). Risk assessments can complement the formulation of a Differential diagnosis which can include Amenorrhoea, Irregular bleeding, Hot flushes, Endocrine causes, Mental Health problems and Drug (Opiates) and Alcohol misuse. Some other causes may include: Urinary incontinence, mood changes, cognitive disturbances, loss of libido, skin changes and weight gain (Perez-Lopez et al, 2013). In the UK, the clinical diagnosis of the Menopause is under researched due to the challenges of assessment (Holloway, 2011). Misclassifications in 'diagnosing' the Menopause can be the result of the 'Menopause transition'. The menopausal transition progresses inconsistently, as regular menstrual cycles can occur after periods of irregularity leading to the misclassification of menopausal diagnosis or classification (Brockie, 2013). The Menopause symptomatology is similar to Opiate Withdrawal (Table 1) such as mood changes, cognitive disturbances, loss of libido and skin changes (Mckeganey et al, 2013).

BOX 2: Examination of injecting sites for Drug Injecting Users

People who inject drugs are vulnerable to viral and bacterial infections. These infections can result in high levels of illness and in death (Public Health England, 2014). The examination of injection sites can provide a useful indication on the timing and duration of drug use. Recent injecting sites show red inflammation and bruising, whereas older injecting sites show a multi-coloured pigmentation in the skin (WHO, 2015). Common injecting sites include the cubital fossa, groin and neck site.

The Clinical Opiate Withdrawal Scale (COWS)

The accurate assessment of opiate withdrawal is important in managing Opioid dependent women in community and inpatient settings. There are various methods of assessment which have been developed to improve on the specificity for opiate withdrawal detection (Tompkins et al, 2009). The Clinical Opiate Withdrawal Scale (COWS) is an eleven item scale used for in the assessment of opiate withdrawal. COWS can be completed in a couple of minutes and can identify opiate withdrawal through serial measurements of vomiting, aches and pains and changes in mood. COWS integrate the monitoring of physical vital signs; pupil dilation, pulse, blood pressure and temperature changes (Wesson & Ling, 2003).

Alcohol Dependence can impair the diagnosis of Opioid Dependence due to similar withdrawal symptomatology and it may be important to consider completing clinical diagnostic tools such as the Severity of Alcohol Dependence Questionnaire (SADQ-C; Stockwell et al., 1983, 1994) and the Alcohol Use Disorders Identification Test (AUDIT) which is a Primary Care intervention to establish alcohol dependence (Henrique-Gonzalez & Patton, 2013).

Opioid dependency depends on the type and severity of Opiate withdrawals to make an accurate clinical assessment (Beck et al, 2013). The comprehensive assessment must determine a current history, social, forensic, past and present medical history. There is a requirement for opiate positive readings in drug urinalysis testing for a formal diagnosis and prescribing medication (NICE, 2015). Opioid detoxification relies on clinical assessment tools such as the COWS for monitoring symptoms associated with Opiate withdrawal. (Wesson & Ling, 2003). Health Complications of opioid dependence include: overdoses, death, blood Bourne viruses such as HIV, Hepatitis B and C (Box 2). The more serious the Opioid dependence is, the greater need for harm minimisation advice on safer sex, needle exchange and immunization (WHO, 2015)

Subjective Opiates Withdrawal Scale (SOWS) and the Objective Opiate Withdrawal Scale (OOWS)

The Subjective Opiate Withdrawal Scale (SOWS) is designed to detect the severity of opiate withdrawal Symptoms (Kheirabadi et al, 2008). SOWS provide patients with an opportunity to be involved in there care, and assess their own symptoms of Opiate withdrawal (Table 1). This scale contains 16 symptoms of intensity the patient rates on a scale of 0 (not at all) to 4 (extremely), and has been shown to be a valid and reliable indicator of the severity of the Opiate withdrawal. Symptoms include “I feel anxious” and “my muscles twitch” which can help reduce the “anxiety” (Table 1) of Opiate withdrawal (Handlesman et al, 1987). SOWS has proven to be a highly valid and reliable indicator for a wide range of Opiate withdrawal symptoms (Kheirabadi et al, 2008).The Objective Opiate Withdrawal Scale (OOWS) provides an “objective measure” of the SOWS and contains 13 physically observable signs, rated present or absent, based on a timed period of observation of the patient. The nurse

normally observes the patient during a 5 minute observation period then indicates a score for each of the opiate withdrawal signs in items 1-13 and then a total score (Handlesman et al, 1987). Symptoms include “yawning” “vomiting” and “hot and cold flushes” (Table 1). SOWS and OOWS may be used as part of initial assessment and monitoring opioid withdrawal using Buprenorphine (Ford et al, 2013).

Table 3: Severity of Dependence Questionnaire (adapted from Gossop et al, 1995)

During the past year:

(1) Did you think your use of [named drug] was out of control?
(2) Did the prospect of missing a fix (or dose) or not chasing make you anxious or worried?
(3) Did you worry about your use of [named drug]?
(4) Did you wish you could stop?
(5) How difficult did you find it to stop, or go without [named drug]?

For questions 1–4 each item is scored on a four-point scale:
0 never/almost never
1 sometimes
2 often
3 always/nearly always

Question 5 is also scored on a four-point scale, but here:
0 not difficult
1 quite difficult
2 very difficult
3 impossible

Severity of Dependence Scale (SDS)

The Severity of Dependence Scale (SDS) is a diagnostic tool which takes a minute of a nurse's time. SDS is a 5-item questionnaire that shows a score on the severity of dependence of Opioids. Each of the five items is scored on a 4-point scale (0-3). The total score is obtained through the addition of the 5-item ratings (Table 3). The SDS indicates the higher the score, the higher the level of dependence (Gossop et al, 1995). Diagnostic tools are highly important in establishing a formal diagnosis which in turn improves public health, well- being and recovery (The Drug Strategy, 2013).

TIMEOUT 4: Opioid Diagnostic Tools Summary

Look at the SDS questionnaire in table 2. What does it tell you about the assessment of opiate withdrawal? Do you feel this is an adequate tool for diagnosing opioid dependence? Several clinical assessment tools have been explored including: COWS, SOWS and OOWS.

The Study of Women's Health Method (SWAN)

Traditionally, the diagnosis of the Pre-menopausal symptoms is assessed through several methods of identification. Predictive models for the Menopause focus primarily on classifying peri-menopause status including age, smoking status, vasomotor symptoms and cycle irregularities as predictors (Whitham et al, 2013). The Study of Women's Health across the Nation (SWAN) is a multi-ethnic, longitudinal, cohort study of US women (Santoro, 2011). The SWAN method creates three classifications of the Menopause:

- Pre-menopausal- (Had a Cycle in the past three months and no changes in cycle length)
- Early- menopausal- (Had a cycle in the past three months and changes in the cycle length)
- Late menopausal; (Had a period in the past 12 months but not within 3 months).

The SWAN shows positive results for accurate diagnosis (Torrens, 2009). SWAN has associated certain patterns of hormones and symptoms with the metabolic status of a woman in menopausal state. The relationship between hormones, body size, ethnicity, metabolic status and cardiovascular disease symptoms risks can vary as women traverse the Menopause and ovarian hormone production eventually ceases (Santoro, 2011). The SWAN Classification method in relation to diagnosis of the Menopause clearly outlines the distinction between early and late Menopause (Whitham et al, 2013).

The Cervantes Scale (CS)

In the UK and other developed countries several specific tools have been designed to identify and assess the Menopause and "quality of life" (Holloway, 2011). The purpose of the 31-item "Cervantes Scale" (CS) is to assess menopausal symptoms in middle aged women experiencing premenopausal and late postmenopausal phases (Monterrosa- Castro et al, 2012). This diagnostic assessment tool was developed following qualitative analysis of questionnaires in Spain relating to menopausal symptoms. The menopausal symptoms assessed included: Hot flushes, heart palpitations, muscle aches, anxiety and vaginal discomfort (Perez- Lopez et al, 2013). It was identified that in clinical practice over the past ten years, the 31 item CS tool was time-consuming. This CS diagnostic tool was "re-developed" and "re-designed" into a 10 item assessment tool to ensure timely effective diagnosis in clinical settings. However, following recent research, the original 31- item was

deemed more valuable for the assessment of 'female Menopause related quality of life'(Brockie, 2013). In contrary, this newly developed 10 item tool, created from the original CS, and is deemed more appropriate for a clinical assessment considering the pressures of staffing in primary care settings (Monterrosa- Castro et al, 2012).

The Menopausal Vasomotor Symptoms Survey (MVS) & Menopause Rating Scale (MRS)

Hot flushes combined with night sweats are common features of hormonal changes associated with the Menopause. The diagnosis of hot flushes can yet be inaccurate in some cases due to dietary and diversity lifestyles (Brockie, 2013). The Menopausal Vasomotor Symptoms Survey (MVS) for Assessment of Hot Flashes is a menopause diagnostic instrument which has shown a more rigorous assessment of "hot flushes" than the Menopause Rating Scale (MRS), which is an 11- item scale for identifying menopausal symptoms (Ratka et al, 2006). MVS is a diagnostic tool created as there can be inaccuracies in clinical practice on how "hot flushes" are understood and evidence suggests they are not well researched. MVS is a valid and reliable test consisting of 39 questions relating to differential dimensions of hot flushes and other health conditions (Table 2). The MVS is a structured questionnaire with a nominal measurement (yes or no answers) and an effective component in establishing "hot flushes" (Ratka et al, 2006). However, this diagnostic tool neglects numerous symptoms for diagnosing the menopause (Table 1).

Timeout 5. Nursing Implications for a misdiagnosis of a health condition.

Have you been faced with a health condition that a diagnosis was uncertain? Have you seen your health colleagues debate a complicated condition? Do you rely on the consultant? What are the likely implications of making a misdiagnosis? How can we best risk assess and protect the safety of our patients?

Implications for the Health Professionals for Misdiagnosing the Menopause and Opioid dependence.

There are a number of clinical concerns in misdiagnosing Opiate Withdrawal Syndrome with the Menopause. Symptoms associated with misdiagnosing the menopause with opiate withdrawal are similar (Table 1). Risks for a misdiagnosis include poor mortality, poor quality of life, physical health complications and chronic disease (Holloway, 2011). A misdiagnosis can impact the service delivery of care, nursing clinical workload, time and knowledge (Clayton & Ninan, 2010). This may lead to malpractice or clinical negligence. In addition, the public health bodies in the UK also play a major role drawing up and implementing guidelines to help prevent chronic disease (Brockie, 2013). The NMC (2015) has drawn up standards for managing clinical negligence. The standards ensure that the patient and public safety is protected and a duty of 'candour' is upheld. Service providers need to provide nurses with regular up-dates on assessment, risk management and ensure appropriate Clinical Diagnostic Tools are utilised. This ensures a misdiagnosis is avoided and the management of relevant health conditions are appropriately managed (Clayton & Ninan, 2010).

Conclusion

In the UK and other developed countries Clinical Diagnostic Tools are used for a comprehensive assessment, risk assessment and monitoring ill health. However, the use of diagnostic tools for the assessment of the Menopause is limited. Assessment of Opiate withdrawal is primarily assessed with urinalysis and Clinical Diagnostic tools. Misdiagnosing natural conditions such as the "Menopause" can have an impact on the quality of life. The misdiagnosis of "Opiate withdrawal" can equally cause harm, both physically and psychologically. In conclusion, Opiate withdrawal and the onset of the Menopause have shown similar symptoms and a misdiagnosis is best avoided with use of an appropriate Clinical Diagnostic Tool.

TIMEOUT 6 Practice profile

Now that you have completed the article, you might want to write a practice profile between 750- 1,000 words. Go to primary health care website: www.primaryhealthcare.net and follow the link to the learning zone for information on how to make a submission.

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